Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for the date of service 07/12/01.
   b. The request was received on 06/28/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Position Statement located on the Table of Disputed
   b. UB-92
   c. EOB/TWCC-62
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. EOB/TWCC 62-form
   c. Carrier Payment History
   d. Copy of the ASC Base Eligibility Public Use File (2002)
   e. Nevada Medical Fee Schedule
   f. Bureau of Workers' Compensation for Commonwealth of PA
   g. Massachusetts Workers' Compensation Act
   h. Mississippi Workers' Fee Schedule for Outpatient Surgery in an Ambulatory Surgical Center
   i. SOAH decisions
   j. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The commission requested two copies of additional documentation via a Fee Letter (MR116) that was mailed to the provider on 07/16/02. The provider did not respond per Rule 133.307 (g)(3). Therefore, the commission could not forward any additional documentation to the Respondent per Rule 133.307 (g)(4). The carrier submitted two responses date stamped 07/03/02 and 08/14/02, which are included in the medical dispute packet and will be reviewed. The responses are reflected as Exhibit II in the commission case file.

III. PARTIES' POSITIONS

1. Requestor: Taken from Table of Disputed Services
"Carrier denied per code 'M' and did not supply documentation of 'methodology' per 133.304 or pay at a 'fair and reasonable' rate. Carrier is also not reimbursing facility consistently as required by the Texas Administrative Code. Carrier's methodology is payment 85% per its own EOB's. However, reimbursement was not at 85%."

2. Respondent: Letter dated 11/20/02
"…Carrier's rate of reimbursement in this case not only meets but exceeds the Act's criteria for payment in all respects. Provider has the burden of proof in this case. The Provider has simply not met its burden of proof under 133.305(e)(1)(F) to establish that its billed charges meet the statutory standards under the Act. On the contrary, the billed amount is grossly excessive as established by the Commission's inpatient surgical per diem rate; the Medicare rate; the payment rate established by the workers' compensation authorities in Nevada, Massachusetts, Pennsylvania, and Mississippi; the anticipated rate under the ASC fee guideline being drafted by the Commission; and finally, the rate determined by SOAH to be fair and reasonable in prior ASC disputes. For these reasons, Provider has not met its burden of proof to establish that its charges of $5,359.25 comply with the Act's statutory standards for reimbursement. Therefore, it is not entitled to additional reimbursement."

IV. FINDINGS

1. Based on Commission Rule 133.307 (d) (1) (2), the only date of service eligible for review is 07/12/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $5,359.25; the amount paid is $900.00; the amount in dispute is $4,404.25.

3. The carrier denied the billed services by exception codes:
"F– Reduction According to Fee Guidelines.";
"M – Reduced to Fair and Reasonable";
"O – Denial after reconsideration."

4. The service was performed at an ambulatory surgical center. No medical documentation was submitted by the provider to indicate what procedure or service was performed.

V. RATIONALE

Medical Review Division's rationale:

The UB-92 indicates services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…." Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be

fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The MFG GI (VI) reimbursement requirements for DOP states, "An [sic] MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

The provider, per rule 133.307(g)(3)(D), must provide documentation "…if the dispute involves health care for which the commission has not established a maximum allowable reimbursement that discusses, demonstrates and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines);". The provider failed to meet the criteria of Rule 133.307 (g) (3) (D).

Commission Rule 133.304 (i) (1-4) places certain requirements on the Carrier when reducing the billed amount to fair and reasonable. The carrier met the criteria of Rule 133.304 (i) (1-4).

Because there is no current fee guideline for ASCs, the Medical Review Division has To determine which party has provided the most persuasive evidence for the services provided. The carrier submitted reimbursement data to explain how it arrived at what it considers fair and reasonable reimbursement. The provider discusses the justification of their charges. The discussion indicates that the carrier's methodology is at 85% per its own EOBs. The provider indicates they will accept 85% of the billed charges. However, the discussion does not document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(d) of the Texas Labor Code. The burden is on the provider to show that the amount of reimbursement requested is fair and reasonable.

Therefore, based on the evidence available for review, the provider has **not** established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 12th day of March 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm